09/28/11

CAREGIVER RELIEF PILOT PROGRAM APPLICATION

Provider Name: _____ Contact Person: _____

1. Are you requesting start-up funding ☐Yes ☐No
   If yes, Personnel/Fringe: $_____
   Furnishings/activities/equipment/supplies: $_____
   Other: Explain: _____
   Please attach Budget for Start-Up Funds

2. Hours of Operation:

Location #1	
Days of Week	**Hours**
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Location #2	
Days of Week	**Hours**
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

3. Number to be served: _____ (range is acceptable-include minimum number that you plan to support up to maximum license capacity)

   Number broken out by Target Groups:

   _____State-Funded (this grant)
   _____State Funded (state family support/respite funds)
   _____Private Pay – DDSN eligible consumers.

4. Please attach Operating Budget. Must include overhead, personnel and fringe not included in start-up, and cost per person, either hourly or some other unit that is fully described. Indicate whether transportation is included/excluded in the rate.

5. Board of Directors Approved: ☐Yes ☐No Contingent: _____ (Date)

6. Provide a description of your pilot in 2 or 3 paragraphs. Include how you will inform potential recipients of this new program and how you intend to phase in new consumers. If you are a DSN Board, please include how you intend to reach out to other service coordination/early intervention providers to assure consumers on their caseloads have equal access to the new program and additional state-funded respite requested for your county(ies). If you are not a DSN Board, explain how you will work with SC/EI providers. Please attach.